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Addressing Mental Health Problems Among TANF Recipients: A Guide for Program Administrators

Final Report

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Preface

Since the passage of the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA), the landmark legislation that significantly altered the public welfare system, state and local policymakers have worked to develop and implement an infrastructure and a set of policies for moving welfare recipients into work. With an emphasis on personal responsibility and state control, the federal legislation not only gives states greater flexibility to design welfare services tailored to local communities, but also requires that they hold families accountable for participation in work or work-related activities. With help from a healthy economy, the welfare policies developed by states have contributed to substantial declines in the number of families receiving cash assistance.

As caseloads decline, state and local welfare policymakers face increasing pressure to develop strategies to move those remaining on cash assistance into work. These are often the clients with the most severe and persistent barriers to employment. Before PRWORA, welfare recipients with personal and family challenges were typically exempt from participation in work or work-related activities. Now, many of these clients are subject to work requirements, time limits, and sanctions for noncompliance. As a result, increasing attention has focused on understanding the types of personal and family challenges that welfare recipients face and how to address these employment barriers.

This guide, prepared by Mathematica Policy Research, Inc., for the Administration for Children and Families of the U.S. Department of Health and Human Services, examines mental health conditions among welfare recipients. It is intended to 1) provide an overview for welfare administrators of the common mental health conditions and the mental health system generally, 2) discuss specifically the types and prevalence of mental health disorders among welfare recipients, and 3) offer strategies for linking welfare recipients with mental health treatment and designing employment services to move these individuals into work. The guide has four sections:

- **Section I: The Prevalence of Mental Health Conditions and Their Influence on Employment** provides definitions for mental health and mental illness as outlined in the U.S. Surgeon General's report and in the Americans with Disabilities Act (ADA). It also provides data on the prevalence and types of mental health disorders among the general and welfare populations, and examines how mental health may influence the probability of employment.

- **Section II: Strategies and Resources for Addressing Mental Health Conditions** offers a map for understanding the available treatment options, the state and local mental health systems, and the options for paying for mental health treatment. This section also covers the difficulties low-income families may have in accessing treatment.
- **Section III: Opportunities for Welfare Offices to Address the Needs of Welfare Recipients with Mental Health Conditions** provides suggestions to staff and administrators of welfare offices on strategies for linking their clients with mental health services. The section begins with guidance on developing a screening process in the welfare office for mental health conditions and then covers the ways to link clients with existing services, use TANF funds to expand existing services, and create new services within the welfare office.
- **Section IV: Meeting the Challenges to Developing Services for Welfare Recipients with Mental Health Conditions** outlines some potential challenges that welfare offices working to address their clients' mental health conditions may confront and suggestions for addressing these challenges. These suggestions include defining clear goals for the welfare office, creating a policy environment that supports participation in mental health services, managing interagency differences in goals or approaches, and educating and training staff.

SECTION I

The Prevalence of Mental Health Conditions and Their Influence on Employment

How mental illness is defined influences public policy, the design and implementation of treatment systems, and general perceptions of those who have a mental illness. The root causes and treatment for mental illness have eluded practitioners for years. Recent advancements uncovering the biological origins of some mental illnesses have resulted in treatment options that allow most of those with a mental illness to lead healthy and productive lives. Mental illnesses are now seen as treatable conditions with hope for recovery to general functioning (U.S. Department of Health and Human Services 1999).

WHAT IS A MENTAL HEALTH CONDITION?

Despite the recent advancements made by mental health professionals in understanding and treating mental health conditions, defining mental illness is still a complicated task. Summarized below are two approaches for defining mental health conditions: the definition outlined in the *U.S. Surgeon General's Report on Mental Health* and the one used in the American Disabilities Act (ADA). Both definitions provide a framework for thinking about mental health in general. It is worth noting that definitions of mental health conditions change over time and are influenced by society's view of functional behavior. After defining mental illness, we discuss the principal tool practitioners use to identify and categorize mental health disorders—the *Diagnostic and Statistical Manual for Mental Health Disorders* (DSM).

Mental Health and Illness Along a Continuum

Included in the *U.S. Surgeon General's Report on Mental Health* is a definition that describes mental health and illness along a continuum. At one end of the continuum is "mental health," the ability to function in productive activities, develop meaningful relationships, and to adapt to change and cope with adversity. At the other end of the continuum is "mental illness," alterations in thinking, mood, or behavior associated with distress and/or impaired functioning. Across a lifetime, few people escape some degree of mental disability or impaired functioning as a result of life circumstances. However, most return to a level of functioning where they can work, maintain healthy relationships, and carry out daily tasks. Those who have a serious and persistent mental illness have more difficulty returning to a productive functioning level, especially without psycho-social or pharmacological treatment. A very small per-

Mental health is "...a state of successful performance of mental functioning resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity."

—U. S. Surgeon General's Report on Mental Health

centage of the population operates at either extreme of the continuum, the majority lie somewhere in between.

Mental illnesses are "...health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning."

—U.S. Surgeon General's Report on Mental Illness

Depending on the type and severity of the mental health disorder, there are varying degrees of impairment that may affect where an individual falls on the continuum. Some mental disorders are more severe than others, particularly when left untreated. For example, when untreated, schizophrenia and other forms of psychosis tend to leave a person more impaired than would an untreated simple phobia. Furthermore, among individuals with the same diagnoses, there is variation in the severity of impairment. In other words, the same mental disorder may affect different people in different ways and affect an individual differently at different times. Framing mental health along a continuum acknowledges the varying degrees of impairment and dynamic nature of mental health.

The American with Disabilities Act (ADA)

An alternative definition is the one provided in the American Disabilities Act (ADA), which defines a psychiatric disability as, "a mental impairment[1] that substantially limits one or more of the major life activities[2] of an individual." This legal definition, designed to protect the rights of those with a mental health condition, is used to determine if an employer has an obligation to make accommodations under the ADA for an employee who has a mental health condition. Typically, the employee seeking an accommodation must provide the verification from a licensed mental health professional that he or she has a mental health condition and document the need for accommodation (Bazelon Center for Mental Health Law 1997). Because the definition is fairly broad and encompasses a wide range of behaviors, it still leaves substantial ambiguity in determining what constitutes a mental health disability (Kramer 1999).

Using the DSM-IV to Identify Mental Health Disorders

Developed by the American Psychiatric Association, the *Diagnostic and Statistical Manual for Mental Health Disorders*, 4th edition (DSM-IV) is recognized in the mental health community as the primary diagnostic tool for identifying mental health disorders. The DSM-IV outlines the distinguishing features of a variety of mental health disorders including associated behaviors, prevalence, course of illness, and the cultural, age, and gender characteristics associated with each disorder. The DSM-IV also identifies behavioral criteria that, if met, indicate that an individual has a specific mental disorder. These criteria allow for consistency among practitioners in diagnosing a mental health disorder. Most insurance companies and public insurance payers require a DSM-IV-based diagnosis before authorizing treatment.

HOW COMMON ARE MENTAL HEALTH CONDITIONS?

Information on the prevalence and types of mental health disorders in the general and welfare population gives insight into the extent and magnitude of these problems. It also provides some important data on factors associated with high levels of mental health conditions—including income, race, and gender.

Prevalence of Mental Health Conditions in the General Population

Approximately one-fifth of the U.S. adult population has a diagnosable mental health disorder. The most common are anxiety and mood disorders such as simple phobias, major depression,and generalized anxiety.

Within a given year, about one-fifth of the U.S. adult population is affected by a diagnosable mental health disorder, and roughly 5 percent of adults are considered to have a "serious mental illness" (U.S. Department of Health and Human Services 1999). Anxiety and mood disorders are the most common classes of mental health disorders with 16 and 7 percent of those between the ages of 18-54 experiencing these types of disorders within a given year, respectively. The most common types of diagnoses are listed in Table I.

Factors Associated with Higher-Than-Average Rates of Mental Health Disorders

Low-income families and certain minority groups experience higher-than-average rates of mental health disorders. Although men and women experience similar rates of mental illness, each experiences certain types of illnesses more often than the other.

According to the national data, income is one of the strongest predictors of a mental health disorder. Those in the lowest socioeconomic group are about two-and-a-half times more likely to have a mental health disorder compared to those in the highest socioeconomic group (Holzer et al. 1986; Regier et al. 1993). High rates of mental health disorders have been found among poor women, particularly those who have been exposed to traumatic experiences in their lives such as adult and childhood abuse, crime victimization, and rape (Bassuk, Browne, & Buckner, 1996; Bassuk et al., 1996; Brooks & Buckner, 1996; Miranda & Green 1999). These experiences, combined with parenting responsibilities (especially single parenthood), financial stress, malnutrition, improper medical care, and inadequate housing arrangements associated with living in poverty, chip away at mental well-being.

In addition, certain minority populations experience higher rates of mental disorders as compared with whites. It is estimated that African Americans and Native Americans have notably higher rates of mental disorders than whites, although some researchers would argue that most of the differences can be attributed to disparities in socioeconomic status (U.S. Department of Health and Human Services 1999). Hispanics and Asian Americans tend to be similar to the white population in the prevalence mental health disorders.

Even though there are few differences in the overall rates of mental illness between men and women, women are more prone to certain mental health conditions such as depression, post-traumatic stress disorder (PTSD), and anxiety disorders (Ulbrich et al. 1989; McLeod & Kessler, 1990; Turner et al. 1995; Miranda & Green 1999). For example, the

The Co-Occurrence of Mental Health and Addiction

While substance abuse is considered within the DSM-IV as a mental health disorder, it is often diagnosed and treated independently of other mental health disorders. However, there are high rates of co-occurrence between substance abuse and other mental health conditions. It is estimated that more than half of those with a mental health disorder also have problems with substance abuse (Ries 1995). Unemployment, hospitalizations, and failures in mental health or substance abuse treatment are very common among people with co-occurring disorders (Callahan 1999). Largely separate funding and treatment systems complicate treatment of co-occurring disorders. Integrated treatment for both mental illness and substance abuse is the most effective approach (Reis 1995).

Table I: Prevalence Rates of Mental Health Disorders Among Individuals Ages 18-54 (U. S. Department of Health and Human Services 1999)	
Type of Disorder	Prevalence (in percent)
Any Anxiety Disorder	16.4
Simple Phobia	8.3
Social Phobia	2.0
Agoraphobia	4.9
Generalized Anxiety Disorder (GAD)	3.4
Panic Disorder	1.6
Obsessive Compulsive Disorder (OCD)	2.4
Post-Traumatic Stress Disorder (PTSD))	3.6
Any Mood Disorder	7.1
Major Depressive Episode (MD)	6.5
Unipolar Major Depressive	5.3
Dysthymia	1.6
Bipolar I	1.1
Bipolar II	0.6
Schizophrenia	1.3
Nonaffective Psychosis	0.2
Somatization	0.2
Antisocial Personality Disorder	2.1
Anorexia Nervosa	0.1
Severe Cognitive Impairment	1.2
Any Disorder	21.0

Being poor, African American, Native American, and female are all associated with higher rates of mental health disorders.

rates of depression among women are twice that of men in a given year. Conditions such as abuse, crime victimization, poverty, stress from the demands of the dual roles in the workplace and at home, gender discrimination, and biological and hormonal changes associated with reproduction may contribute to higher rates of depression among women (NMHA 2000).

Prevalence of Mental Health Conditions among Welfare Recipients

Between one-fourth and one-third of current welfare recipients have symptoms associated with a mental health condition. [3]

There is wide variation in the reported rates of mental health conditions among welfare recipients. Estimates differ depending on how mental health conditions are defined and measured, and by the research methodology. In the National Survey of America's Families, 35 percent of low-income families reported having poor mental health in at least one of four areas, including anxiety, depression, loss of emotional control, and psychological well-being (Zedlewski 1999).[4] Researchers in Michigan found similar rates of mental health conditions (36 percent) among welfare recipients (Danziger et al. 1999). In general, it is estimated that between one-fourth and one-third of current welfare recipients have a serious mental health problem (Sweeney 2000).

Major depression is the most common mental health disorder among welfare recipients, followed by post-traumatic stress disorder (PTSD) and generalized anxiety.

The prevalence of depression among the welfare population is startlingly high. In a Michigan study of barriers to employment among female welfare recipients, 27 percent of the study sample screened positive for clinical depression (Danziger et al. 1999).[5] Using the same measure for depression, 42 percent of long-term welfare recipients in Utah had clinical depression in the year before the interview. This rate is nearly seven times that of the general adult population (6.5 percent) (Barusch et al. 1998). In addition, the same study found that 57 percent of these long-term welfare recipients were at risk for current depression.[6] Other studies have found sizable differences in the rates of depression when comparing welfare recipients and nonrecipients (Olson & Pavetti 1997; Leon & Weissman 1993). While it is clear that depression is the most widespread mental health condition among the welfare population, it is not clear to what extent the depression precedes unemployment and receipt of cash assistance or if the depression is a product of the stress and frustration associated with those experiences. Regardless of which comes first, once a person experiences depression, symptoms such as sleeplessness, loss of self-esteem, social withdrawal, apathy and fatigue often interfere with his or her ability to obtain and sustain employment and raise a family.

Recent studies suggest that welfare recipients suffer from clinical depression at four to seven times the rate of the general adult population.

Generalized anxiety (7 percent) and post-traumatic stress disorders (15 percent) are also prevalent among the welfare population (see Table II). Welfare recipients experience generalized anxiety disorders, and post-traumatic stress disorders at rates substantially higher than the general population.

HOW AND HOW MUCH DOES THE PRESENCE OF A MENTAL HEALTH CONDITION AFFECT EMPLOYMENT?

Those with mental conditions are more likely to have poor and sporadic work histories, to be unemployed, and to be receiving cash assistance.

Mental health conditions, in general, are a considerable barrier to work, and as such, are associated with high rates of unemployment. Nationally, between 70 and 90 percent of working-age adults with a serious mental illness are unemployed (Baron, et al. 1996; National Institute on Disability and Rehabilitation Research 1993). Mintz et al. (1992) looked at the relationship between depression and the general capacity to work and found that about half (52 percent) of depressed patients experienced some level of functional work impairment. In a review of research, Johnson and Meckstroth (1998) reported that mental health conditions not only result in lower rates of labor force participation, but also in reduced work hours and lower earnings.

Michigan researchers were among the first to examine the direct link between mental health conditions and employment among welfare recipients (Danziger et al. 1999). These researchers found that having major depression significantly decreased the likelihood that a woman on

Table II: Prevalance of Specific Mental Disorders Among Welfare Recipients			
Disorder	**U.S. General Adult Population**	**Female Welfare Recipients in Michigan**	**Long-Term Welfare Recipients in Utah**
Major Depression	6.5%	26.7%	42.3%
Post-Traumatic Stress Disorder	3.6%	14.6%	15.1%
Generalized Anxiety	3.4%	7.3%	6.7%

For many, the symptoms and stigma associated with mental health conditions, as well as the side effects of medication make consistent employment challenging.

welfare will work (although, other disorders such as generalized anxiety and post-traumatic stress disorder had no noticeable effect on employment). Focusing on the relationship between mental health conditions and welfare receipt, Jayakody et al. (1999) found that having one or more of the four psychiatric disorders included in the study[7] increased the likelihood of receiving cash assistance by 32 percent. In a related study, researchers reported that those who were diagnosed with major depression were 40 percent more likely to receive cash assistance than those without these symptoms (Leon & Weissman 1993).

The degree to which work is affcted depends upon the severity of the mental health condition. Some of the ways that mental health conditions can affect employment include:

- **The symptoms and developmental deficits from a mental illness may create challenges in a work environment.** Behaviors such as loss of concentration, irritability, fatigue, and anxiety associated with some mental illnesses can be difficult to manage in a work environment. Furthermore, when a mental health condition goes untreated for an extended period of time, or begins during the developmental years, the individual may experience education and skill deficits (Zuckerman et al. 1993).
- **The irregular nature of mental illness may create disruptions in work.** Mental illness is often episodic and unpredictable in nature. Those who are experiencing mental health difficulties may need some additional work accommodations until the condition is under control. Many of the types of jobs available to welfare recipients are low-wage, service sector positions that are less likely to offer the flexibility that some individuals with mental conditions require.
- **Side effects of medication may at times affect the quality of the work performed by an employee with a mental health condition.** Most of the medications used to treat mental health disorders have side effects that may disrupt the work environment. Side effects include physical symptoms such as drowsiness, dizziness, dry mouth, nervousness, headaches, shakiness, confusion, and weight gain. These side effects may create problems that reduce productivity. In addition, individuals who are taking medication for a mental

health disorder may stop taking the medication that allows them to function effectively in a work environment. Thus, just when a person gets stabilized, they may go off their medications and begin to have trouble again.

- **Limited work history and educational attainment leave many with a mental health condition in entry-level, low-wage jobs.** A mental health condition may cause interruptions in work and school that create skill and knowledge deficits, and it may cause limited interpersonal skills, which in turn influence both the likelihood of being hired and the types of jobs people with severe mental illness qualify for. Seventy-five percent of those with a severe mental illness are employed in entry-level, low-wage positions without health insurance benefits (Baron et al. 1996).
- **The stigma associated with mental illness reduces the likelihood that those with a mental health condition will seek treatment or request accommodations from their employer and may create difficulties among co-workers.** Despite intensive efforts to educate people about mental illness, it is still associated with a strong stigma that often prevents people from receiving treatment or asking for work accommodations. In some cases, the symptoms associated with the illness, such as apathy or anxiety, interfere with the process of seeking help. Furthermore, the stigma of a mental health condition may create difficulties in relationships with co-workers, which could decrease the likelihood of maintaining work.
- **Some employers may be reluctant to hire those with a mental health condition.** Even though ADA legislation prohibits discrimination in hiring on the basis of disability, many employers are cautious about hiring those with mental health conditions because of the perceived difficulty in terminating an employee with a disability if they do not perform according to expectations (Butterworth & Pitt-Catsoupes 1996). Another concern expressed among employers is the time, money, and lack of expertise in providing workplace accommodations.

NOTES

1. An impairment is substantially limiting if it lasts for more than several months and significantly restricts the performance of one or more major life activities during that time.
2. "Life activities" are defined as learning, thinking, concentrating, caring for oneself, performing manual tasks, working, or sleeping.
3. It is worth noting that because studies of the welfare population typically screen for only a few specific disorders, the data tend to underestimate the prevalence of all mental health conditions among that population. Also, TANF caseload declines may account for an increase in prevalance of thse conditions among those in the current TANF caseload.
4. Low-income is defined in this study as less than 200 percent of the federal poverty level.

5. Using DSM-IIIR (*Diagnostic Statistical Manual*, version IIIR) criterion.
6. Current depression was measured using the CES-D depression scale.
7. Psychiatric disorders included in the study: (1) major depression, (2) generalized anxiety disorder, (3) agoraphobia, and (4) panic attack.

SECTION II

Strategies and Resources for Addressing Mental Health Conditions

Approximately 15 percent of the U.S. population uses mental health services within a given year (U.S. Department of Health and Human Services 1998). The services available include a range of therapeutic approaches offered in varied settings and funded through a collection of public and private sources. This section provides a road map to he resources available for treating mental health problems.

THE CONTINUUM OF MENTAL HEALTH SERVICES

Even though mental health disorders can at times be difficult to diagnose, in general, they are treatable. Services for treating mental health conditions are commonly described as ranging on a continuum from least to most intensive. Hospitalization, or inpatient treatment, is the most intensive of these options. Increasingly, less intensive options like partial hospitalization and outpatient services have emerged as the preferred approach to treating mental illness. The primary treatment options along this continuum are listed here from most to least intensive.

Inpatient/Residential Programs

Inpatient or residential treatment is generally prescribed when an individual poses an immediate danger to self or others, or in cases where individuals cannot adequately care for themselves. Most inpatient treatment is provided in residential settings such as state hospitals, drug and alcohol treatment centers, or psychiatric units within general hospitals.

The trend toward deinstitutionalization over the last few decades has contributed to a decline in the number of individuals receiving inpatient treatment. Even for the most severe cases of mental illness there is an increasing focus on finding ways for people to live in community based settings where they have more control over their lives.

The high cost of services, between $400 and $550 per day, also contributes to the less frequent use of inpatient treatment. In 1996, residential treatment accounted for 40 percent of the overall mental health expenditures, but only served 4 percent of those seeking mental health services (Mark et al. 1998).

Partial Hospitalization Programs

Partial Hospitalization Programs (PHP) now provide many of the intensive mental health services that institutional settings used to pro-

vide. They are used primarily to avoid inpatient hospitalization or to offer individuals leaving inpatient treatment help with reintegrating into outpatient or other community-based care. Two factors have contributed to the shift in services from inpatient to PHP programs. First, with deinstitutionalization there has been an emphasis on providing services in the least restrictive environment in order to improve the quality of life of those with a severe and persistent mental illness. Second, the cost of inpatient services has increased substantially. Between 1986 and 1996 the cost of residential care nearly tripled from approximately $20,000 per patient year to $60,000 per patient year (Mark et al. 1998).

PHP's vary in how they are structured and what services they deliver. Clients may attend a PHP anywhere from three to six hours a day, and up to five days a week. The services provided within PHP generally include psychotherapy and medication management. Clients are typically monitored by a physician. Some programs integrate independent living skills, art therapy, and other types of psycho-social activities.

Clubhouse Programs

Clubhouse programs offer individuals with severe mental illnesses outpatient treatment and supervision. Individuals who join a clubhouse can participate in daily activities and are expected to play some role in the functioning of the organization. The focus of clubhouse programs is on creating a consistent and structured atmosphere with an emphasis on developing basic skills and relationships. Specific activities at a clubhouse can include include bookkeeping, preparing meals, janitorial responsibilities, among others. Some clubhouse models also offer assistance in obtaining employment and housing.

Outpatient Treatment

Outpatient treatment is the most frequently used type of treatment used in the continuum of care. It is less intensive than Partial Hospitalization Programs, but still has a strong therapeutic emphasis. Outpatient treatment include services such as individual or group therapy, marriage and couples counseling, family counseling, and medication management. Outpatient treatment is typically provided by a psychiatrist, psychologist, licensed clinical social worker, mental health counselor, or another licensed mental health professional.

The length of time a client receives outpatient treatment varies by the individual's treatment needs and ability to cover the cost of services. Managed care organizations and private insurance companies frequently limit the number of counseling sessions the client can utilize within a given year. Those who rely on public funds to cover the cost of mental health treatment may also be restricted to approved providers and a limited duration of benefits (CHCS, 1998).

Adjunct Services

Adjunct services can be described as non-therapeutic interventions for individuals with a mental health condition. These interventions might include support groups, such as Alcoholics Anonymous and grief and loss groups, that are facilitated by participants rather than a licensed clinician. Other adjunct services might include housing assistance, legal assistance, food banks, or vocational training.

TREATMENT OPTIONS FOR THOSE WITH A MENTAL HEALTH CONDITION

Whether an individual is receiving inpatient, partial hospitatilization, or out-patient treatment, there are a range of specific pharmacological and psycho-social therapies that may be administered, alone or in combination, to address the symptoms and causes of mental health conditions.

Some of the more common treatment options are discussed below.

Psychotherapy

Psychotherapy is a process in which clients present their problems and work with a mental health professional to develop effective ways of understanding and handling their problems. Treatment can be provided individually, with couples, families, or groups. There are a variety of different approaches to psychotherapeutic treatment including psychodynamic, behavioral, gestalt, cognitive, humanistic, among others. More recently, clinicians have developed short-term, behavioral-based therapies that have had remarkable success in treating both mood and anxiety disorders (U.S. Department of Health and Human Services 1999). In most states psychotherapy can only be performed by a licensed service provider or a trained individual who is working toward licensure and working under the supervision of a licensed professional.

Medication

Recent advancements and discoveries made in neuroscience and molecular genetics have not only broadened our understanding about the physical and genetic basis of many mental health disorders, but have also dramatically expanded the number of drug treatment options for those with a mental disability (NIMH 1995; U.S. Department of Health and Human Services 1999). As a result, there has been a sharp increase in the use of prescription drugs to treat mental health or substance abuse conditions (Mark et al. 1998). Depression, schizophrenia, and other disorders can be managed with medications that have fewer side effects than existed a decade ago.

Crisis Intervention Services

In recent years, the number of crisis services available to individuals with mental health conditions has increased substantially. Many large companies offer Employee Assistance Programs (EAP) where a distressed worker can call 24 hours a day, 7 days a week, for short-term help with a mental health need. Crisis services are also available as a public service in most areas for individuals struggling with thoughts of suicide or other severe mental health conditions. Most local communities offer short-term "time-out" services for parents who are frustrated and on the verge of physically harming their children.

Life Skills and Other Types of Psycho-Social Training

Many programs include life skills or other types of psycho-social training as part of their treatment services. Some workshops may emphasize communication, anger management, building and maintaining interpersonal relationships, and other types of soft skills. Other training may include more independent living skills such as personal hygiene, money management, and safety awareness. This type of treatment can be provided by any trained professional and does not require a professional license to administer.

Factors Associated with Successful Treatment

Through interviews with individuals who have recovered from a mental health condition, Sullivan (1994) identified the following five factors as being associated with successfully treating a mental illness: medication, community support/ case management, self-will/ self-monitoring, vocational activity (including school), and spirituality.

Transitional or Supported Employment

Transitional or supported employment focuses on helping participaants to work in paid employment with close and supportive supervision (Pavetti et al. 1997). Over time, participants are given opportunities to increase work responsibilities and training until they are gradually moved into unsubsidized employment. Supported work activities range from building repair and maintenance to providing child care services. Some supported work programs may include components of case management and supportive services, such as mental health and substance abuse treatment.

Alternative Therapies

There is a broad range of alternative therapies that have been successful in treating certain mental health conditions (CMHS 2000b). For example, yoga, meditation, and other stress reduction techniques have been used to treat anxiety and mood disorders. Aerobic physical activity such as brisk walking and running have been found to improve the mental health for people who report symptoms of anxiety and some forms of depression. While some alternative therapies may be useful with certain disorders, discretion should be used in selecting the proper treatment.

Program Example:

The State of Rhode Island

Through their Community Mental Health Centers, The State of Rhode Island offers individualized vocational services for people with severe and persistent mental illness. These services include individual job placement, vocational evaluation and assessments, job coaching, and supported employment.

For more information contact Judy Bolzani at (401) 767-9163.

Informal Social Supports

Informal social supports such as family, friends, and faith organizations can be vital to the treatment of mental health conditions, particularly in certain ethnic groups. In African American and Hispanic populations, for example, these informal supports are especially important when culturally sensitive therapies or bilingual services are not available within the area (U.S. Department of Health and Human Services 1999).

THE ODDS OF SUCCESS

Mintz et al. (1992) found that behavioral impairments, including missed time, decreased performance, and significant interpersonal problems, are common features of depression that appear to be highly responsive to drug or psycho-social treatment. Approximately 80 percent of those who are treated for depression show drastic improvements, and most people return to normal functioning within six to eight weeks (NIMH 1999; American Psychiatric Association 1994). Like depression, other disorders are treatable, and in some cases, improvement may occur in a relatively short time (Hrynyk 1997; National Mental Health Association 1997; National Alliance for the Mentally Ill 2000; National Technical Assistance Center for State Mental Health Planning 1999). However, the success of treatment is still highly contingent upon the type and severity of the disorder and the genetic and personal characteristics of the client. Cook and Steigman (2000) emphasize a comprehensive approach to recovery including a service mix of treatment, rehabilitation, and support.

MENTAL HEALTH SERVICE PROVIDERS

While there is considerable variation across states regarding the funding and operation of the mental health system, the following organizations are the most common providers of mental health services.

Community-Based Mental Health Centers (CBMHCs)

These clinics, established during the 1960s to address the mental health needs of lower-income populations, are operated using a combination of public and private funding sources. Services that may be offered through a community-based mental health center include counseling, medication management, inpatient care, and support groups. A sliding fee scale based on personal income is commonly used to determine fees at CBMHCs. Those fees range from $5 to $50 an hour for treatment. In most locales, Medicaid fully covers fees for services at CBMHCs.[1]

Private/Public Social Service Organizations

In general, these are nonprofit organizations with broad social service missions that have contracts with a state or county to provide mental health services, often to very specific populations. For example, a state or county may contract with a public/private social service organization to provide mental health services to truant teens or prison inmates. These organizations receive public funds for the purposes of this contract, but use other private funds to fulfill their organizational missions generally. Private/public social service organizations provide similar services to the community-based mental health clinics—including counseling and support groups—except that they are less likely to have a psychologist or psychiatrist on staff who can prescribe and monitor medical treatment. These organizations commonly offer a sliding fee scale and fees comparable to community-based mental health clinics.[2]

Health Maintenance Organizations (HMOs)

The number of states that use managed care arrangements to provide mental health services for low-income families has increased significantly in recent years (Scalett et al. 1997; NTAC 1997b). All but four states now use some type of managed care system to provide mental health services through Medicaid (Scalett et al. 1997). There is wide variation in the types of mental health services available and in how they are provided under managed care. In some cases, mental health services provided through an HMO are integrated into a comprehensive physical and mental health care program; in other cases, mental health services are partially or completely contracted out to a distinct organization.

Private Practices

A private practice is a for-profit business consisting of one or more psychologists, psychiatrists, or mental health counselors.[3] Mental health services typically provided through a private practice are counseling and medication management. Fees for therapists in private practice range from $60 to $125 an hour. Rates for psychologists and psychiatrists are

Getting Information on a Local Mental Health System

As local information hubs, national and local mental health associations provide consumers with detailed information about how to access mental health treatment within their local communities. National and local mental health associations are nonprofit organizations working to improve the mental well-being of all Americans, especially those with mental health conditions, through advocacy, education, research, and service. Although these organizations generally do not provide any direct treatment services, they operate as the information hubs linking clients with mental health services within states and local communities. For information from the National Mental Health Association call (800) 228-1114 or contact it online at http://www.nmha.org.

Another excellent resource for information on mental health services is the Center for Mental Health Services Knowledge Exchange Network (KEN). Call 1-800-789-2647 or visit the KEN website at http://www.mentalhealth.org.

generally higher than for licenced clinical social workers, mental health couselors, and psychiatric nurses. Depending on the insurance provider, there may be restrictions on the amount of treatment and on who can provide it (a psychologist versus a psychiatrist, for example). Medicaid often covers treatment with a private practitioner, with restrictions on the type of provider, and on the amount of treatment and reimbursement.

Private Clinics

Private clinics are profit or nonprofit organizations for which the primary source of funding is private insurance or direct payments from individuals. These clinics are often geared toward long-term inpatient treatment or hospitalization. Some private clinics may receive limited public funds and designate "public beds," space available to clients who cannot pay the standard fees. Because they are unlikely to offer a sliding fee scale, services at private clinics are most accessible for people who have private health insurance or can pay for services themselves. Fees for counseling in a private clinic generally range from $50 to $125 an hour. Inpatient care may cost $400 to $550 a day.

Program Example:

Kandu Industries, Inc.

Kandu Industries in Ottawa County, Michigan was organized in the early 1960s as a program designed to serve young adults with physical and mental health disabilities. Since then, Kandu industries has expanded their services to include a supported work program for welfare recipients and others with employment barriers. Workers placed at Kandu Industries provide manufacturing and assembly services for area companies. Between 70-80 percent of TANF recipients obtain jobs after their training and work experience at Kandu Industries.

For more information contact Peg Beall at (616) 355-3214.

Vocational-Rehabilitation Agencies

All states have agencies that provide vocational rehabilitation services for individuals with disabilities. These services include counseling, evaluation, training and job placement, supported work programs, and job coaching. While vocational rehabilitation services are available to individuals with all types of disabilities, there are often specialized services for those with a psychiatric disabilities. State vocational rehabilitation agencies will often contract with community organizations to provide local services. In order to qualify for vocational rehabilitation, an individual must have a medically documented disability that substantially limits his or her ability to work and the individual must need vocational rehabilitation services in order to work. Priority is given to those individuals with severe disabilities.

Supervised Housing Facilities

Often called halfway houses, board-and-care facilities, supportive housing programs, or group homes, these living arrangements offer daily supervision to people with mental health conditions. While, many supervised housing facilities are oriented toward individuals recovering from substance abuse, there are also facilities serving individuals with other severe conditions like schizophrenia. In most cases, only individuals who face a significant mental impairment would live in supervised housing situation. These programs generally emphasize supervision and structure, not treatment, but they may also offer mentoring, coaching, or support groups. Individuals who are living in supervised housing will most likely receive counseling or medication through a separate provider.

PAYING FOR MENTAL HEALTH SERVICES

In 1996, the nation spent $69 billion on diagnosing and providing mental health services. Funding for these services comes from a variety of sources, including Medicaid, federally sponsored Community Mental Health Block Grants, private health insurance, allocations by state governments, and consumer out-of-pocket payments. The public sector, which covers more than half the cost of mental health treatment, is the most common source of funding (U.S. Department of Health and Human Services 1999; Mark et al. 1998). The primary public and private funding sources are described in greater detail below.

Medicaid

Medicaid is a major source of support for public mental health services, providing one-third of all funding for community-based mental health programs (National Technical Assistance Center for State Mental Health Planning, 1997a). State and local health departments use Medicaid dollars to pay for a percentage of the cost of services directly or they can pay a capitated fee to a managed care organization that provides mental health services. While states must provide a minimum amount of services as outlined in the federal guidelines, they have considerable flexibility in the amount, scope, and duration of services (Center for Health Care Strategies, 1998).

Community Mental Health Services Block Grants (CMHSBGs)

CMHSBGs were established in 1981 through the Public Health Service Act. In fiscal year 2000, more than $356 million is being distributed to states through CMHSBGs. The money from CMHSBGs, which funds agencies and clinics that provide mental health services, can also be used to pay for direct services. To obtain grant money, states submit plans annually to the federal Center for Mental Health Services describing how block grant funds will be used to provide comprehensive community-based mental health services. States vary in how they allocate block grant funding. They either allocate funds directly to community mental health centers, distribute money based on a competitive bidding process, or use some combination of allocation and competitive bidding.

State/Local Funding

State funds are used to supplement the CMHSBGs to create an infrastructure for public mental health services. According to national figures, state and local funding accounts for about 18 percent of all mental health expenditures (U.S. Department of Health and Human Services 1999). The amount of funding allocated by state and local governments varies by state.

Private Health Insurance

Almost a third (27 percent) of the total mental health care expenditures are covered by private health insurance companies. Even though

How State and Local Expenditures on Mental Health Services Can Count toward TANF Maintenance-of-Effort Requirement

State and local expenditures on mental health services can sometimes count toward the state's TANF maintenance-of-effort (MOE) requirement. MOE is an annual cost-sharing requirement of receiving the TANF block grant. Generally, state funds not used either to meet Medicaid requirements or as a condition of receiving federal funds under another program can count toward the MOE requirements if a state uses the funds to provide "eligible families" with benefits and services that are reasonably calculated to accomplish a TANF goal. See "Helping Families Achieve Self-Sufficiency: A Guide on Funding Services for Children and Families through the TANF Program," at http://www.acf.dhhs.gov/programs/ofa/funds2.pdf.

private health insurance has become less generous in reimbursing mental health services in recent years, a greater number of families have mental health coverage (Mark et al. 1998). It is anticipated that private health insurance companies will continue to be a major payer for mental health services as states mandate more equity in mental health coverage. To date, mental health parity legislation has been developed and signed into law in 30 states.[4]

Private Pay (Out-of-Pocket)

Many of the private health insurance companies offer limited mental health coverage, which means that consumers are left with a portion of the cost. While mental health parity legislation attempts to improve the amount of coverage offered through private insurance plans, the implementation and enforcement of this legislation varies by state. Clients may also chose to pay for mental health treatment out-of-pocket to avoid seeking insurance reimbursement which may jeopordize confidentiality. In all, consumers pay about 17 percent of the total mental health costs out-of-pocket (Mark et al. 1998).

Research suggests that the cost of treatment and the lack of insurance coverage are, by far, the most formidable barriers to treatment for people with a mental health condition.

DIFFICULTIES IN ACCESSING TREATMENT

Despite the range of successful treatment options available, the majority of those who are diagnosed with a mental health condition do not receive treatment.

Studies indicate that less than one-third of adults with a diagnosed mental disorder receive treatment (DHHS 1999). The reasons individuals with a mental health condition forgo treatment vary. For some, the cost of services prevents individuals for seeking treatment; for others it's the lack of culturally sensitive therapies or the stigma associated with mental illness. These reasons can become even more acute and seemingly insurmountable for low-income families and welfare recipients. These families are not only less likely to have financial resources, they may be more geographically isolated and less able to depend on a consistent support system. Difficulties that individuals may face in accessing treatment include:

- **Cost of services.** In a recent national study funded by the Robert Wood Johnson Foundation, worry about cost was listed as the highest reason for not receiving mental health treatment, with 83 percent of the uninsured and 55 percent of the privately insured listing this as a reason (Sturm and Sherbourne 1999). Another study of low-income women found that cost and lack of insurance were the foremost barriers to treatment (Miranda & Green 1999). While Medicaid pays for treatment for many welfare recipients, low-income families without Medicaid or other private insurance may find it nearly impossible to access mental health services. In addition, welfare recipients who leave welfare for work may be concerned about the loss of Medicaid as a resource in paying for care.
- **Stigma associated with mental health disorders**. Despite concentrated efforts to reduce the stigma surrounding mental health condi-

tions, the portrayal of mental illness in the media, the limited treatment methods in the past, and the ingrained social "taboo" around discussing mental health conditions all perpetuate the deep fear and embarrassment associated with identifying and treating a mental health condition.

- **Lack of culturally sensitive and bilingual services**. While the current mental health system is working to develop culturally sensitive and bilingual services, these services are not available in all areas. According to the Center for Mental Health Services, "culturally competent services incorporate respect for and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems" (CMHS 1998). This is an important issue not only for determining the ways psychotherapy or counseling services are conducted, but for identifying appropriate drug therapies, because drug metabolisms vary by gender and among different racial and ethnic groups (U.S. Department of Health and Human Services 1999).
- **Concern with the quality of mental health treatment.** Some individuals may forego treatment because they question the quality of mental health services. Others in treatment may stop receiving services because the treatment is not meeting their needs. The quality of mental health treatment is an ongoing concern, particularly services for low-income and other disadvantaged populations.
- **Living in a rural location**. There are two challenges to receiving mental health in a rural area. First, there is a general lack of service providers in these areas and that lack can limit the treatment options. And second, many of those living in close knit rural communities may be even more cautious and fearful about the social ramifications and stigma associated with seeking mental health treatment.

NOTES

1. These clinics often prioritize serving those individuals with severe mental disabilities. This may make it difficult for those suffering from chronic, but not severe, disabilities to receive treatment.
2. One type of private organization that is becoming increasingly involved in providing social services is faith-based organizations. Examples of large, national faith-based organization involved in providing social services are Catholic Community Services and Lutheran Social Services.
3. Primary care physicians are also an important provider of mental health services because they commonly prescribe medications for the treatment of mental health conditions.
4. The term "mental health parity" refers to insurance coverage for mental health services that is subject to the same benefits and restrictions as coverage for other health services (National Mental Health Council, 1998).

SECTION III

Opportunities for Welfare Offices to Address the Needs of Recipients with Mental Health Conditions

As practitioners and researchers understand more about the number of welfare recipients who face mental health conditions and the ways in which these conditions can inhibit steady employment, welfare offices may want to design innovative program approaches to link their clients with mental health services. There are many ways that offices could approach this goal. Some may want to use TANF funds to expand services available in existing local mental health programs; others may choose to focus on building relationships with local mental health agencies to improve their referral system; and others may want to co-locate trained mental heath counselors or develop supported work programs.

IDENTIFYING WELFARE RECIPIENTS WHO CAN BENEFIT FROM MENTAL HEALTH SERVICES: DESIGNING A SCREENING PROCESS

Regardless of the approach taken by a welfare office to link clients with mental health services, the first step is to identify the clients who would benefit from such services.

Currently, systematic identification of mental health conditions happens less often in welfare offices than assessment for low skills, learning disabilities, or even substance abuse. There are several reasons for this including the specialized training required to assess mental health conditions and the lack of easy-to-administer, yet reliable, screening tools. Yet, if welfare offices are interested in connecting clients to specialized mental health services (whether in-house or through referrals), they will need to create a process for identifying clients who can benefit from these services.

To link clients who may have a mental health issue with a skilled mental health professional, welfare agencies need to design a systemtic process for screening clients for mental health impairments.

The process of identifying a mental health condition includes two stages:

- **Screening** is a process for detecting individuals within a population who are more likely to face mental health conditions using common symptoms or characteristics of those conditions.
- **Assessment** is a more in-depth examination of the nature and extent of an individual's mental health condition that may lead to diagnosis.

Clinical assessment of mental health conditions is different from assessment of other barriers to work like low skills or even substance abuse because the process must be conducted by a professional trained

in psychology or psychiatry. Because of this, assessment will almost always occur outside the welfare office (unless trained counselors have been co-located in the welfare office). The task for welfare agencies is to link their clients who may have a mental health issue with a skilled mental health professional who can provide an in-depth diagnostic assessment. In order for this link to occur, welfare offices need to design and implement a systematic process for screening clients for mental health impairments. In most cases, offices will want this process to be as simple and to require as few resources as possible. With those goals in mind, the process can still vary greatly in terms of who is screened, who conducts the screening, when the screening occurs, and what instruments or techniques are used. Each agency will need to work through a series of decisions that will tailor their screening process to the specific needs of the clients and the structure and philosophy of their existing services.

Decisions in Designing a Screening Process for Mental Health Conditions in a Welfare Office

While staff may be making decisions every day that define their agency's approach to screening and assessment, there is not always a systematic consideration of how to create an efficient and useful screening process. The benefit to approaching these considerations systematically is that the resulting system will be grounded in a distinct set of goals and designed to most effectively meet those goals. There are six interrelated questions that will guide the design of a screening process for mental health impairments among welfare recipients.

How will screening information be used?

The structure of a screening process should be based on this first and most important consideration: How will the information collected through the screening process be used? There will always be local policy, programmatic, and budgetary limits on the services provided to clients and the program requirements on those clients. Still, information about a client's mental health condition can be used to design more flexible, responsive, and appropriate services for that client. The most common ways that welfare offices use screening information are:

- To tailor self-sufficiency and service plans to require mental health counseling or participation in other mental health services
- To identify clients in need of referrals to mental health agencies or organizations
- To assign clients to caseworkers in the welfare office with training in mental health issues
- To provide estimates of the proportion of clients that face mental health conditions
- To identify clients that may be extempt from work requirements or those who may need workplace adjustments or accommodations

To a large extent, the way(s) in which screening information will be used by a local agency will determine the direction of the remaining decisions about who will be screened, when it will occur, who will conduct it,

and what tools or techniques will be used to screen clients. For this reason, agencies should carefully consider how information about a client's mental health condition can be used, given local philosophy and service structure.

Which clients will be screened?

The next step is to define the target population. Three common ways that agencies target screening are:

- **Screening all clients.** Screening can be a component of the services provided to all clients during the initial intake process or during a mandatory program component like a life skills class. If screening information is going to be used for exemption decisions and designing self-sufficiency plans, it may make the most sense to screen all clients.
- **Screening clients who have an unsuccessful job search.** Screening may be targeted more narrowly to those clients who appear to be less employable. This approach would be most practical if screening is going to be used to individualize the program requirements and self-sufficiency plan for a client. The drawback of this approach is that resources for employment services may be been spent on some clients who were unable to benefit from them.
- **Screening clients based on caseworker discretion.** Another way to narrow the population of clients who will be screened is for caseworkers to identify clients whose past or present characteristics suggest the potential for a mental health condition. Caseworkers might look for patterns over time—like long-term welfare receipt or an unstable work history—that their experience suggests are associated with mental health disorders. Alternatively, caseworkers could be trained to identify the behavioral signs of common mental health disorders. In either case, this narrowed approach could be useful if the screening information will be used primarily for personalizing services or for assigning clients to specialized caseworkers.

The ADA and Screening

The American with Disabilities Act of 1990 (ADA) requires that public agencies implement consistent eligibility processes and make reasonable accommodations in the delivery of services to meet the needs of clients with disabilities. The law's focus on consistent services suggests that broad-based screening of all clients is the safest approach. However, if agencies choose to use a targeted screening process aimed at clients with specific characteristics or experiences, they should be sure to carefully consider and document the rationale for the criteria they have selected.

When will screening occur?

The decision of when to screen clients for mental health conditions again goes back to the previous decisions on how the information will be used and which clients will be screened. If all clients are going to be screened for these issues, then screening should occur up front in the intake process or during some mandatory program component like a life skills class. If screening is going to be targeted to a narrower group of clients, then it may occur as the case worker becomes aware of some information about the client or after a client has been unsuccessful in finding a job over a specified period of time.

Who will conduct the screening?

Screening could be conducted by all caseworkers for their own caseloads or by specially trained caseworkers whose jobs include this distinct responsibility. Who conducts screening will depend on whether

the screening process is going to target all clients or a more narrowly defined population and whether the screening is going to occur during a program component like a life skills class or during individual meetings between client and caseworker. The screening tools or techniques that the agency uses in this process may also influence this decision. Some tools will require more time or training than others, and it may be most efficient to designate staff who will be responsible for conducting screenings.

What screening tools or techniques will be used?

A screening tool can be a useful way to standardize the identification of mental health conditions among clients. Unfortunately, very few screening tools that do not require substantial training of the test administrators have been developed for mental health conditions. The few screening tests that can be administered by staff without clinical training have not been used extensively with welfare recipients. This does not rule out their use in the welfare office, but it makes it more difficult to know how consistent and valid their results will be with this particular population.

Appendix A provides a list of available mental health screening tools. While there is no one tool that is recommended for the welfare population, there are important characteristics that welfare offices might want to consider when selecting a tool. These characteristics include:

- **Validity/Reliability.** These terms are used to describe how consistently and accurately a testing device measures the intended attributes. Information on validity and reliability is often highly technical and may not be available for all tools. If it is not possible to get formal information on the validity of a tool, it may be helpful to look into whether other welfare offices or clinics serving low-income populations have used the tool and how helpful or accurate they found it to be. Offices that consider developing screening tools in-house should be aware that tools that have not been tested for validity and reliability risk misidentifying clients who do not have a mental health condition or not identifying clients who do.[1]
- **Ease of administration.** Different screening devices require varying levels of training and preparation to administer. Welfare offices may want to look for tools that require little if any training and are administered in the most convenient format. Some offices may prefer paper tests, others might find computer-based tests to be the easiest to administer.
- **Accessibility to low-skilled, learning disabled, and non-English speaking clients.** Many screening tools are now available in languages other than English. If the tool is self-administered it is also important that it is accessible to those with learning disabilities or very low skills.
- **Cost.** Some mental health screening tools are available free of cost. For those that are not, the welfare office may have to purchase test booklets, manuals, and/or scoring cards. Cost becomes a more significant consideration the more clients an agency plans to screen.

Relationship-Based Assessment

Some organizations that work with welfare recipients have begun using an ongoing process for identifying and assessing barriers called relationship-based assessment. This is the practice of assessing a client through a serious of conversations based on a trusting relationship between caseworker and client. While this process should not be used in welfare offices to conduct a clinical assessment of a client's mental health barriers, it could be used as an alternative approach to screening. This technique does require caseworker training and agency emphasis on developing relationships between client and caseworker. It is also helpful to have small caseloads and a personalized approach to case management.

- **Length.** Many mental health screens are available in versions of varying lengths. In general, welfare offices may want to look for short instruments because they are less time-consuming. However, it is a good idea to pay particular attention to the validity of short versions of well-tested tools because they may be less likely to provide consistently accurate results.

In addition to, or instead of, using screening tools, welfare offices may want to train staff members to be able to identify signs of mental disorders. This training will be particularly important if the agency has chosen to screen clients based on caseworker discretion. An agency might develop a screening system in which case workers refer clients for screening with a formal tool only after they have informally identified certain signs of mental conditions in those clients. One benefit of training caseworkers to be more knowledgeable about the symptoms or characteristics of mental conditions rather than relying solely on screening tools is that this better understanding of mental health conditions may lead caseworkers to provide more sensitive and appropriate case management.

How will clients who screen positively be connected to an agency/ individual who can conduct diagnostic assessment?

The last decision in structuring a screening process for mental health impairments among welfare recipients is determining how clients who are identified as having a potential mental health condition by a screening tool will be connected to a professional who can conduct a full diagnostic assessment. If psychologists or psychiatrists are co-located in the welfare office, this may a simple process of assigning a client to another caseworker. It is more likely that this process will involve referrals outside the welfare office. In this case, agencies may need to develop relationships with certain public and/or private mental health agencies, create referral lists for caseworkers, determine how assessments will be paid for, and develop a plan for monitoring the process. Whatever form this process takes, it is important that agencies be prepared that these changes may complicate the intake process and require additional human and financial resources.

EXPANDING MENTAL HEALTH SERVICES AVAILABLE TO WELFARE RECIPIENTS

Welfare offices can expand mental health services for their clients by linking clients to existing services, using TANF MOE funds to expand existing community programs, and developing new services in the welfare office.

Addressing mental health conditions among welfare recipients is a challenging task for state and local welfare offices. Given the complex nature of mental health and the lack of experience and training among most welfare service providers in identifying and treating mental health conditions, it is not surprising that few models exist for linking welfare recipients with mental health services. Yet, without treatment, those with mental health conditions may not succeed in moving from welfare to work and remaining self-sufficient in the long-term.

Assessing a Client's Employability

In addition to screening for mental health conditions, welfare offices may wish to conduct assessments to evaluate whether a client's mental health condition acts as barrier to work. Tools to identify mental health conditions will not necessarily provide this information. A client's job-readiness can be assessed through continuing discussions with the client, reviewing the client's job history, and monitoring the client's job search. Several assessment tools are also designed specifically for assessing employability. Two common ones include the "Barriers to Employment Success Inventory (BESI)" available at http://www.psychtest.com and the "Employee Reliability Inventory (ERI)" available at http://www.oraonline.com/renewal/html/reliability.html.

Discussed below are three types of promising strategies for addressing the needs of welfare clients with mental health conditions: 1) linking clients to existing services, 2) expanding the capacity of existing mental health programs, and 3) creating new mental health programs within the welfare office. While considering these strategies, keep in mind that whether a strategy actually requires expanding existing capacities or building new ones depends significantly on the local system of mental health services. The more informed staff and administrators are about the capacities and limitations of that system, the more informed their efforts to expand available services for welfare recipients can be. Also, there is very little conclusive research on which of these or other strategies will most successfully provide welfare recipients with mental health conditions the services they need to become and stay employed. Strategies are included here because the lessons of welfare offices, mental health providers, and/or employee assistance organizations suggest that they could be promising.

Program Example:

The State of Illinois

In Illinois, a consortium of mental health and substance abuse treatment service providers developed a program for individuals with co-occurring disorders. Treatment is designed with an integrated focus addressing both substance abuse and mental health conditions. Vocational training is included within the range of services provided by this program. Although this program does not directly target TANF recipients, about half of the clients in this program receive cash assistance.

For more information contact Mimi Bazuin at (815) 391-1000.

Linking Clients to Existing Mental Health Programs

In order to link clients who have been identified as having a mental health condition with an agency that can provide appropriate services, the welfare office needs to have an organized and reliable referral process. This requires developing relationships with area mental health organizations, keeping updated contact and capacity information about those agencies, and informing caseworkers about the agencies that can accommodate clients covered by Medicaid or clients without insurance.

Another way to more effectively link welfare and mental health service providers is to develop interagency collaboratives. This kind of a forum can bring together staff from various agencies and with a great diversity of knowledge and experience to formulate policy, integrate services, and improve the coordination of treatment.

The following are three promising collaborative approaches to linking welfare and mental health services:

- **Organizing interagency meetings between state and local welfare policymakers, mental health system administrators, and other major community agencies.** Regular meetings between staff members from different agencies and organizations could cover topics like how to effectively coordinate policy that affects welfare recipients with mental health conditions and how to remove barriers to service delivery for those individuals. It may be useful to include staff at many levels in these meetings, including staff who have diect experience with case management and referrals.
- **Co-locating mental health workers within local welfare offices**. This approach involves housing mental health workers employed by a local mental health organization in the welfare office. A co-located staff member could work part- or full-time in the welfare office and their responsibilities could include conducting screening and/or assessment, providing counseling or other mental health services to all clients identified as having a mental health condition, or providing services to a specialized caseload.

- **Forming interagency case staffings.** In case staffings, workers from a variety of agencies come together to discuss a particular case and to address personal and family challenges of a family receiving cash assistance**.** Case staffings can be beneficial (especially for particularly difficult cases) because staff with differing expertise and knowledge work together to identify strategies for assisting families. This option may be more resource intensive than others and may be best suited for difficult or high priority cases.

Expanding the Capacity of Existing Mental Health Programs

One of the likely challenges to addressing the mental health needs of welfare recipients is that in many communities the need for mental health services far exceed the capacity of existing local mental health programs. The availability of treatment can be particularly limited for low-income families, especially those without insurance coverage. There are ways in which welfare offices might use TANF funds to expand the capacity and accessibility of existing services in their communities. Federal TANF funds cannot be used for "medical services". (This term is defined by the individual states but would generally preclude use of TANF funds for items such as hospitalization or physician vists.) However, there are very few other restrictions on how federal funds are used to support welfare recipients moving into work. In some cases, state funds might also be used to address service needs that restricted federal TANF funds are not able to, including medical services. Here are several ways that welfare offices might help expand the capacity of existing mental health programs:

- **Funding staff at a community-based mental health clinic.** By using TANF or MOE funds to pay for additional staff members or a portion of staff time, welfare offices can increase the capacity that a community-based mental health clinic has to serve new clients.[2]
- **Funding an Employee Assistance Program (EAP) at a community-based mental health clinic.** Many private-sector companies have developed successful EAPs for their employees who may be struggling with personal or work-related stress. Building on this experience, a welfare office might fund an EAP through an existing community-based mental health clinic to provide support for welfare recipients (and other low-income families) managing the challenges of working with a mental health condition. These programs, designed to deal with temporary crises, can act as preventative measures that reduce the need for more substantial assistance. EAP services can include short-term counseling, problem solving sessions with trained counselors, and a 24-hour hotline. For those who do need more long-term interventions, an EAP can provide another opportunity for screening and referral.
- **Funding slots in a supported work (or other employment-focused) program.** Many communities have existing supported work programs or other programs that help individuals with mental health conditions manage the challenges of employment. Welfare offices may want to consider paying for a designated number of client slots in these programs.

Program Example:

Steps to Success in Portland, Oregon

In Steps to Success, case managers identify clients, based on the information they have collected during case management, who may need mental health services and refer those clients to on-site mental health counselors who then conduct a short screen for mental health issues.

- **Providing funds to support a satellite office of a mental health clinic.** This idea may be particularly appropriate for addressing mental health conditions in rural areas. One of the greatest difficulties for those with a mental condition who live in a rural area is the lack of mental health service providers within the community. One option is to contract with a mental health professional living outside the area to work for one or two days a week in a rural mental health office or welfare office.

Develop Mental Health Programs in Welfare Offices

In addition to expanding the capacity of existing mental health programs, welfare offices may want to build capacity for addressing the needs of recipients with mental health conditions within the welfare office. As discussed earlier, successfully expanding services within the welfare office depends first on a clear and systematic screening process. In addition, there are many other steps that welfare offices might take to expanding services, some more complex and costly than others. Some ideas to consider include:

- **Training mental health caseworkers.** Welfare caseworkers could be trained to handle a specialized caseload of clients with mental health conditions. These caseworkers might be trained to conduct screening and casework with specific attention to the challenges that clients with mental health conditions face in obtaining and sustaining employment.
- **Developing programs that encourage informal support networks.** Some community organizations have had success with peer-oriented programs that help individuals with mental health conditions develop stable and supportive relationships. A welfare office might develop a program that matches clients who have mental health conditions with peers who can act as a mentors, role models, and friends.
- **Encouraging intensive case management**. In this service delivery model, a case manager is assigned a fewer number of welfare cases, but the caseload is made up mostly of individuals who are hard-to-employ and require additional attention and coordination of services in order to move into work. This case management model would be helpful for developing flexible work requirements and providing consistent services to clients with mental health conditions.
- **Hiring mental health counselors.** A full-time mental health counselor on staff at a welfare office could conduct screening and assessments and handle specialized caseloads or be available for consultation on any case. One advantage of this strategy is that a clinical social worker or psychotherapist could provide services like counseling and clinical assessment that trained welfare caseworkers could not.
- **Developing a supported work program**. The work history of welfare recipients with mental health conditions is often poor and sporadic. For those with little work experience, supported work, or supervised job placements, may be an effective short-term employment option. This may be a particularly good option for those re-

Program Example:

Tennessee's Family Services Counseling Program

In partnership with the University of Tennessee, the Tennessee Department of Human Services has developed a program for addressing barriers to work among Tennessee's "Families First" TANF recipients. Ninety-five master's level *Family Service Counselors* are out-stationed within local welfare offices and community-based agencies to provide a variety of services to help TANF recipients become employed. Services provided by these counselors include in-depth psycho-social assessments; intensive clinical case management; home visits; and employment-based, short-term therapy. Family Service Counselors have received over 2,500 referrals since the program began February 2000.

For more information contact Holly Cook at (615) 313-5465 or hcook2@mail.state.tn.us.

ceiving mental health treatment. The benefit of a supported work environment is that it offers welfare recipients a chance to gain employment experience and have the flexibility and services needed while they receive treatment.

- **Developing an Employee Assistance Program (EAP).** An EAP (described in the previous section) located in the welfare office might provide temporary assistance and problem-solving training that focuses on assisting welfare recipients with mental health conditions to manage life and work stress.

NOTES

1. It is important to note that all screening tools will identify some individuals who do not have a mental condition—or "false positives." Because a positive screen is never equivalent to a diagnosis, it is particularly important that welfare offices have a structure in place to refer clients who screen positively for additional assessment.
2. The restriction against using Federal TANF funds for medical services suggests that welfare agencies interested in using Federal TANF funds to fund staff time at a community-based mental health clinic may need to define distinct staff positions that will not include any responsibilities that are "medical" in nature and to carefully document the roles and responsibilities of those positions.

SECTION IV

Meeting the Challenges to Developing Services for Welfare Recipients with Mental Health Conditions

While there is tremendous local authority and flexibility over the funding and administration of TANF programs, welfare offices may still face some challenges in addressing the mental health disorders of their clients. Considering ways to address these challenges up front will help staff and administrators design more successful approaches to providing mental health services to welfare recipients.

DEFINING CLEAR GOALS FOR THE WELFARE OFFICE

The "work first" philosophy of most welfare programs requires (to varying degrees depending on the state) that welfare recipients show consistent work effort in order to receive assistance. Because of the effects that mental health conditions can have on work, recipients with mental health conditions may face greater challenges to obtaining and maintaining work than those without these conditions. As a result, these clients may need different types of supports and allowances to help them achieve their employment goals. Allowing for individualized services and activities that may not be work-oriented (such as treatment) can seem contrary to the goals and purpose of the welfare office.

It is important for state or local staff and administrators to consider these issues early on and to define clear goals for serving clients with mental health conditions. It is also possible for these goals to be congruent with a work-first approach and with the needs of clients with mental health conditions. A screening process for mental health conditions may be used to determine exemptions, but in a work-first approach, it need not be used for that purpose only. Instead, the screening process could be used to identify clients needing further assessment and individualized, flexible services that help them to find and keep employment. For example, an office might set the goal of providing flexible services that would address the significant barriers to work faced by each client and help them move into stable employment. This work-oriented goal, while clearly involving requirements for the client, also leaves room for providing support services and activities to address mental health conditions.

Welfare offices can define goals that are congruent not only with a "work-first" philosophy, but also with addressing the needs of clients with mental health conditions.

CREATING A POLICY ENVIRONMENT THAT SUPPORTS PARTICIPATION IN MENTAL HEALTH SERVICES

Administrators and staff may also want to consider the way in which the state policy and regulations concerning TANF could be interpreted or

modified to best support clients in need of mental health therapy in order to successfully move off welfare and into work. Some examples of how to do this include:

- **Expanding allowable work activities to include mental health treatment**. For some families combining mental health treatment with the pressure of full-time work and family responsibilities may be an unrealistic expectation, particularly for long-term welfare recipients who have not been in the labor market for an extended time. Adjusting the allowable work activities to include mental health treatment or a supported work program may allow families to incorporate smaller employment demands such as part-time work while they learn to manage their condition.
- **Extending time limits for those with a mental health condition who are actively participating in treatment and working toward achieving self-sufficiency**. If the goal of welfare reform is to instill the value of personal responsibility, it may be reasonable to extend the amount of time those who are actively working on their mental health conditions can collect cash assistance or exempt clients from a time limit altogether. Currently, 24 states have exempted individuals with mental health conditions (using a variety of definitions) from their time limit.

MANAGING DIFFERING AGENCY GOALS OR APPROACHES

Many of the strategies outlined in this guide involve collaboration between multiple state and local agencies. It is likely that these collaborations will highlight some differences between agencies in terms of philosophy or approach to client services. This is a common hurdle involved with inter-agency collaboration, but one that is far outweighed by the benefits of creating tighter links between clients and the services that they would benefit from. If an agency decides to pursue a strategy that involves collaboration with another agency or organization, it may be helpful to recognize up front any important differences in the missions or cultures of each agency and how those differences will be managed.

Adding significant numbers of new clients from the welfare system may overwhelm a mental health system already stretched too thin. This makes it all the more important for welfare offices to consider how TANF funds can support mental health services, easing the burden on the mental health system.

For instance, the primary goal of a welfare agency may be to help clients find employment as quickly as possible, while the primary goal of a mental health agency may be to improve its clients' quality of life. These differences could prompt very different decisions about the type and structure of services provided through this collaboration. However, if the differences are identified and discussed during the planning process, compromises can be made to develop services that meet both goals.

Another important issue to consider when forming collaborations between welfare and mental health agencies is that many community-based mental health systems already have considerable difficulty meeting the mental health needs of the community. For this reason, many clinics give priority to clients with severe and debilitating mental illness. Adding significant numbers of new clients through screening and referral processes at the welfare office—many of whom may have chronic, but not severe disabilities—may overwhelm a system already stretched thin.

This challenge makes it all the more important that agencies collaborate and that they begin with clear descriptions of the goals and concerns of all participants. It is also important that welfare staff and administrators consider ways in which the welfare office could support an expansion in the capacity of the existing service system or develop new services to minimize the burden on the mental health system.

EDUCATING AND TRAINING STAFF

Welfare offices that attempt to address the needs of clients with mental health conditions may find it challenging that staff in the welfare office have limited knowledge of mental health issues and staff in the mental health programs have limited knowledge of the specific needs of welfare recipients. Educational efforts that address these gaps will increase the likelihood that the welfare office can work with the existing mental health community to better address these barriers. Education and training might target staff at state and local welfare offices, staff in the mental health field, and/or employers.

Programs for Welfare Office Staff

- **Training case managers to understand the basic signs and symptoms of the more common mental health disorders.** Screening and assessment tools may aid in the detection of mental health conditions. It is also possible for caseworkers to become more savvy about recognizing the signs of certain mental illnesses. Being able to recognize the signs of common mental health disorders might help caseworkers decide which clients to screen, to refer to outside organizations, and/or to provide with specialized case management.
- **Informing case managers about the eligibility requirements and process for accessing SSI disability benefits.** Some welfare recipients may never be able to maintain steady employment as a result of their conditions. For these families, SSI may be viable option. Some states, including Maryland, screen every TANF applicant for potential referral to SSI.
- **Teaching case managers how to identify and encourage informal support networks for welfare recipients.** Immediate and extended family, friends, and religious institutions can be assets in helping a welfare recipient into work. These informal sources of support can continue to encourage and motivate clients after they leave welfare for work.

Programs for Policymakers, Providers, and Employers

- **Informing state and local welfare policymakers about the prevalence and service delivery needs of welfare recipients with a mental health condition.** In order to more effectively move welfare recipients into work, policymakers need to understand the types of personal and family challenges among the welfare population, including mental health conditions. Many of the traditional strategies for moving clients from welfare to work may not be as successful with this population, and policymakers have a large role in de-

termining whether the environment of the welfare office is flexible enough to address these differences. Welfare agencies may also want to caution policymakers that because not all mental health conditions can be successfully treated and not all barriers to employment completely removed, the employment and retention rates for this population may always be lower than for welfare recipients generally.

- **Teaching mental health service providers about the characteristics of welfare recipients and some of the personal and family challenges they face.** To improve the linkages between the welfare and mental health systems, state and local welfare offices may seek to involve mental health service providers in the mission of moving welfare recipients into work. Familiarizing mental health service providers about work requirements and other welfare-related policies will help counselors target treatment to help welfare recipients accomplish their employment goals.
- **Helping employers understand common mental health conditions and how these conditions may affect work.** Such an education program could inform employers about their responsibilities for work accommodations under the Americans with Disabilities Act, the mental health difficulties common to welfare recipients, and some suggested techniques for helping recipients manage their disabilities within the workplace. The welfare office could also provide employers with a list of community resources to refer employees who are experiencing mental health issues.

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APPENDIX A

Screening Tools for Identifying Clients with Mental Health Conditions

There are numerous tools available for screening and assessing mental health conditions. However, many of the tools are lengthy and must be administered by a trained mental health professional. Below are descriptions of some mental health screening tools that offer short versions and do not necessarily require extensive training to administer.

Beck Depression Inventory - Second Edition (BDI-II)

This is a 21-item self-report instrument for measuring the severity of depression in adults and adolescents 13 years and older. It was developed for the assessment of symptoms corresponding to criteria listed in Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV). Documentation is available to support its reliability and validity. For more information, contact Harcourt Brace Educational Measurement at 1-800-211-8378.

General Health Questionnaire (GHQ)

The GHQ is available in a variety of lengths, including a 12-item scale. It is available in many languages and has been used internationally and among different socioeconomic classes. It has not specifically been tested among the welfare population. Information on its reliability and validity is available. The user's guide for the GHQ-12 costs approximately $70 and a pack of 100 test packets costs approximately $43. For more information, visit: http://www.nfer-nelson.co.uk/html/health/ghq/.

HANDS Screening Tool

This is a confidential 10-question screening test for depression that is available on the Internet. This test is sponsored by the National Mental Health Association and can be completed on-line or downloaded for personal use free of charge, but cannot be distributed without permission. For more information, visit: http://www.depression-screening.org/.

Mini International Neuropsychiatric Interview (M.I.N.I.)

This is an abbreviated psychiatric interview based on the DSM-IV. It can be used by trained interviewers who do not have training in psychology or psychiatry. For more information, visit: http:www.medical outcomes.com/.

SF-36 Health Survey

The SF-36 is a general health survey that includes a five-item mental health scale. This screening tool may be useful to welfare offices because it assesses not only symptoms but social role functioning. Information is available on its reliability and validity. For more information visit: http://www.sf36.com/.